Circle Health Group Limited

The Sloane Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Services were contactable for support seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Some services relied upon agency staff to ensure safe staffing levels were achieved and the service generally lacked consistency with their record keeping.
- Not all services had clear written protocols to guide staff to care for patients and not all departmental risk assessments were kept up to date.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good 	Our rating of this location stayed the same. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually. However:

Summary of findings

- Compliance rate with record keeping was below the provider's target.

Diagnostic imaging

Good

We have not previously rated this location. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and all staff were committed to improving services continually.

However:

- The mammography radiation risk assessment was out of review date.
- There were no written protocols for magnetic resonance imaging (MRI) procedures.

Summary of findings

Surgery

Good 

The service provided day surgery model and did not accept referrals that would require an overnight stay for patients. They completed surgery across a number of specialities including pain, foot and ankle and facial cosmetic surgery.
Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and mostly kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were contactable seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued by their local team. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the local NHS services to plan and manage services and all staff worked to improve services continually.

Summary of findings

However:

- The service relied upon agency staff to ensure they had safe staffing levels at all times and some information was not always consistently included in patient records, due to duplication.

Medical care (Including older people's care)	Good	Medical care is a small proportion of hospital activity and only incorporates endoscopy procedures. The main service was surgery and endoscopies were completed by the surgical team in theatres and patients were cared for in the same wards, with the same nursing and support staff, following endoscopies. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Summary of this inspection

Background to The Sloane Hospital

The Sloane Hospital is an independent hospital run by Circle Health Group Limited. In January 2020, Circle Health Holdings Limited (Circle) acquired the BMI Healthcare Limited group. The hospital is located in South London and serves the local population treating privately funded patients and NHS patients. The hospital has a registered manager in place.

The hospital offers day case surgery, endoscopy services, diagnostic imaging and outpatient care, including physiotherapy. The hospital ceased to care for children and young adults following our last inspection and now only cares for adults over the age of 18. It has two wards to care for patients recovering from surgery, two theatres, diagnostic imaging department and an outpatient department.

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service.

How we carried out this inspection

We used our unannounced comprehensive inspection methodology. You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that the provider must have protocols and risk assessments for diagnostic imaging are in place and are reviewed every 12 months.

Action the service SHOULD take to improve:

Surgery:

- The service should continue to progress their action plan to improve consistent record keeping.
- The service should continue to work to reduce their reliance on agency staff usage in theatres.

Outpatients:

- The service should ensure staff maintain contemporaneous record in respect of each service user.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Diagnostic imaging	Requires Improvement	Inspected but not rated	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Medical care (Including older people's care)	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. We reviewed the staff training matrix and found most nursing staff and all physiotherapy staff had completed all their mandatory training modules. Senior staff told us there were arrangements for two newly recruited nursing staff to complete outstanding modules.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training requirements included a range of areas such as basic life support, immediate life support, care and communication of deteriorating patient, conflict resolution and dementia awareness.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff confirmed they could access their mandatory training records and received alerts when training was due.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and adults formed part of the mandatory training programme for staff. All clinical staff had completed safeguarding adults training up to level three while health care assistants (HCAs) completed level two safeguarding adults training.

The service did not see children and young people. However, staff were provided with the right level of training to recognise and report abuse in children. The service offered level two children safeguarding training and all staff had completed the training.

Good

Outpatients

Staff knew how to identify adults and children at risk of, or suffering significant harm and worked with other agencies to protect them. Staff gave examples of concerns they would report and knew the contact details for the agencies they would report to. This included the provider's safeguarding team and local authorities.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. We observed that all areas of the clinic were visibly clean and free from clutter. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as handwashing and using hand sanitisers when entering and exiting the unit and wearing personal protective equipment (PPE) when caring for patients.

There were sufficient numbers of hand washing sinks available, in line with the Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks and instructions on how to effectively decontaminate hands were displayed above the sinks.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Disposal curtains were labelled with the date they were last cleaned. Staff informed us they changed curtains every six months or when dirty.

The service generally performed well for cleanliness. Staff achieved a compliance rate of 100% in the hand hygiene audit from October to December 2022. During the same period, staff achieved 97% in the infection prevention and control (IPC) audits.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of patients' and their families. The outpatient and physiotherapy unit had sufficient number of consultation rooms. Corridors, rooms and toilets were spacious and could accommodate people using wheelchairs. There was lift access to the first floor of the hospital where the outpatient unit was located. The lift was not in use during our inspection and repairs had been scheduled however, a stair lift was available to access the outpatient department in the absence of the lift.

The service had enough suitable equipment to help them safely care for patients. Staff were trained in the safe use of any new equipment introduced at the location. Patients could reach call bells in clinical areas.

Equipment, including resuscitation equipment had been safety checked and was subject to monitoring. Gym equipment within the physiotherapy unit were serviced annually and labelled with the service date.

Fire safety and evacuation equipment was available throughout the department and we saw evidence that fire equipment safety checks were completed.

Safety signage was fitted to the door of the ophthalmology room where laser procedures took place. This helped to keep staff and patients safe by deterring people from entering when procedures where underway.

The service had a dedicated laser protection advisor via a contract with an NHS trust. There were local rules in place which set out instructions to ensure staff followed national guidance for the safe use of laser equipment. Consultants were required to read the local rules and sign to acknowledge that they understood and agreed to work in accordance with the rules. The service also had a laser protection supervisor to ensure staff followed local rules and national guidance.

Staff disposed of clinical waste safely. There were adequate arrangements for handling, storage and disposal of clinical waste, including sharps. Waste was segregated with separate bins for general waste and clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff completed risk assessments for each patient using a recognised tool. This included identifying potential risks such as allergies and assessing patients' suitability for treatment. For example, physiotherapy staff completed an assessment of patients' medical history for risk factors such as dizziness or respiratory issues that might affect exercise plans.

All staff had completed basic or intermediate life support training to care for patients in an emergency. Medical assistance was provided by the resident medical officer (RMO) and the patient's consultant. Patients requiring further medical intervention were transferred to the hospital via an ambulance in line with the provider's policy. The service had an agreement for the transfer of critically ill patients to an NHS trust.

Staff completed an adapted "five steps to safer surgery" World Health Organisation (WHO) checklist for minor laser procedures carried out in the ophthalmology room. The service achieved 100% in the WHO checklist audit results for October and November 2022. It achieved 99% December 2022.

Staff shared key information to keep patients safe when handing over their care to others. Staff followed a standard process to share clinical information with GPs when necessary.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe. The outpatient clinics were staffed by registered nurses and health care assistants (HCAs). In addition, specialist breast nurses supported consultant led breast clinics. The physiotherapy department consisted of three full time physiotherapists including the manager, three part time physiotherapists and two hand therapists that worked across site.

Managers could adjust staffing levels daily according to the needs of patients. Nursing cover was calculated dependent on the number of clinics running and the numbers of patients attending clinic as well as other factors such as procedure support and chaperoning. There was always a minimum of two qualified nurses on duty. The physiotherapy department always had a minimum of two therapists on duty.

Data received from the provider showed that the service had no vacancies.

Good

Outpatients

The service did not use agency staff. The provider's bank staff were used to fill gaps in rotas where required. Bank staff were familiar with the service and had received a full induction.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Outpatient clinics were led by consultants who worked under practising privileges. Practising privilege is a well established system of checks and agreements, whereby doctors can practise in hospitals without being directly employed by them. Clinics were scheduled to suit each specialist's availability and obligation as part of their practising privileges contract.

A resident medical officer (RMO) was on duty 24 hours a day and could cover any emergencies.

The Medical Advisory Committee managed practising privileges for consultants. The provider checked all medical staff had valid professional registrations, medical indemnity insurance, completed mandatory training and appraisals.

Records

Staff mostly kept detailed records of patients' care and treatment. Most records were clear, up-to-date, stored securely and easily available to all staff providing care. However, audit compliance rates were below the provider's target.

Patient notes were mostly comprehensive. Records were stored securely in filing cabinets. We reviewed eight patient records across the outpatient and physiotherapy department. Most records were detailed and included details of assessments carried out, consultant notes, details of patient medical history, diagnosis, details of investigations and treatment, and discharge letter to the GP.

Three of the records reviewed did not include details of previous consultations or medical history. However, we saw that comprehensive details of the patients' medical history and consultations were held on a system accessible by the consultant.

The hospital carried out quarterly patient records audit. The last two audits from April to July 2022 and August to November 2022 showed an amber rating with compliance rates of 81% and 85% respectively. The audit identified that consultants were not contemporaneously documenting on patients records during outpatient appointments. An action plan was implemented following the audit. Staff were required to carry out spot checks on patient records on regular basis to ensure any non-compliance was flagged as early as possible.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The provider had a medicines management policy, which described the storage, prescribing, and safe administration of medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. A member of the pharmacy department was available to speak to patients about their medicines and provide advice and support to staff on the ward.

Good

Outpatients

Staff completed medicines records accurately and kept them up-to-date. We reviewed two prescription charts and saw they were completed, signed and dated. Staff recorded information about patient allergies.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in a secure cabinet and in locked rooms. We reviewed a random sample of medicines and found that they were in date. Controlled drugs were kept at the pharmacy.

Medicines requiring cold storage were stored in locked fridges and the temperature was monitored daily. Staff also monitored the temperature of the room where medicines were kept.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff reported 54 incidents between January and December 2022.

Staff informed us they received feedback from the investigation of incidents, both internal and external to the service. They met to discuss the feedback and looked at improvements to patient care. For example, checklists were reviewed to ensure staff labelled patient samples accurately following an incident involving a misspelt name.

Staff understood the duty of candour. They told us it involved being open and transparent and giving patients and their families a full explanation if and when things went wrong.

Is the service effective?

Inspected but not rated

We do not rate effective in outpatient services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies on the provider's intranet system. Policies were in date and developed in line national guidance such as the National Institute of Health and Care Excellence (NICE) guidance.

The service carried out a programme of audits to monitor staff compliance with guidelines. This included hand hygiene, infection prevention and control, WHO checklist, patient records and bi-annual physiotherapy records audit. The service achieved 93% compliance against a target of 95% in the last physiotherapy audit covering the period August to December 2022. The audit identified a gap in documentation of patient weight and the walking aid provided. An action plan was implemented to ensure staff documented patient weight and checked the walking aid to ensure it was appropriate for weight restrictions.

Good

Outpatients

Nutrition and hydration

Patients had access to beverages and water in the waiting areas.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff ensured patients were comfortable when carrying out individual assessments.

Staff prescribed, administered and recorded pain relief appropriately. We saw this was recorded in patients' prescription charts.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards.

Patients attending the hospital often required diagnostic imaging service or surgical procedures. The hospital carried out a comprehensive programme of repeated audits to check improvements in these related services. Outcomes for patients were positive, consistent and met expectations, such as national standards.

The serviced used patient reported outcome measures (PROMs) to assess the quality of care for physiotherapy patients. Patient outcomes showed improvement in patient rehabilitation in line with expectations.

Managers shared and made sure staff understood information from the audits. Findings from audits were shared at team meetings and during team brief sessions.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had completed relevant training required for their role. Managers regularly reviewed the registrations and revalidations of relevant clinic staff to make sure they were up to date.

Managers gave all new staff a full induction tailored to their role before they started work. New members went through a probationary period and completed competency training.

Managers supported staff to develop through yearly, constructive appraisals of their work. The hospital's appraisal data showed staff received yearly appraisals. Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We reviewed notes of team meetings which were well attended.

Good

Outpatients

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. This included a daily "comm cell" briefing session where daily clinical and operational needs were discussed with the senior team and resources were allocated for that purpose.

Patients could see all the health professionals involved in their care at one-stop clinics. This included appointments with consultants and imaging staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. Medical staff, nurses and allied staff worked together to deliver patient care. Staff told us they had good working relationships with other members of staff in the hospital.

Seven-day services

Key services were available seven days a week to support timely patient care.

The outpatient service operated six days a week from 8am to 9pm, Monday to Friday; and from 8am to 3pm on Saturday.

Physiotherapy was opened from 8am to 8pm on Monday to Thursday, 8am to 4pm on Friday, and from 8.30am to 12.30pm on Saturday.

The pharmacy was opened from 8am to 4pm from Monday to Friday.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service gave patient's relevant information promoting healthy lifestyles and support.

Staff assessed each patient's health at every appointment and provided support for individuals to live a healthier lifestyle. The physiotherapy department provided a range of classes for patient rehabilitation. These included pilates, yoga and gym sessions. Patients were given an exercise plan to support their rehabilitation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe their roles and responsibilities under the Mental Health Act. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decision about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They clearly recorded consent in patients' records.

Good

Outpatients

Staff had received training in Mental Capacity Act and Deprivation of Liberty Safeguards as part of their safeguarding adults training.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Our observation of patient care showed staff engaged well with patients, they were polite, caring and compassionate.

Staff were discreet and responsive when caring for patients. They followed policy to keep patient care and treatment confidential. Discussions took place in dedicated consulting rooms to protect patient privacy and dignity.

Patients said staff treated them well and with kindness. Patients and their relatives spoke positively about their care. They said staff were “extremely good” and confirmed they would recommend the service.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Patients were offered a chaperone for consultations involving intimate examinations or procedures and staff had completed chaperone training.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Our observation of patient care showed staff were re-assuring and comforting to patients. Patients confirmed that staff helped to put them at ease.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff understood the anxiety or distress associated with procedures and engaged patients to ensure they were comfortable.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Good

Outpatients

Staff made sure patients and those close to them understood their care and treatment. Patients were given clear information regarding the benefits and risks of their treatment and were given the opportunity to ask questions.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff engaged well with patients and involved patients in their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. We reviewed patient satisfaction survey response for outpatient services. Between June to November 2022, 98% of patients rated their overall experience of the service as very good or good. Patients described staff as “helpful and understanding”, “very polite”, “highly professional” among other compliments.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The department operated an appointment based service from Monday to Saturday. Appointments were arranged with patients, at a time and date convenient for them. A wide range of outpatient services were available to meet patient need. Specialist services offered included ophthalmology, orthopaedics, breast care, urology, pain management and physiotherapy.

The service had links with other sister locations to provide additional patient services including surgery.

The service received referrals from NHS trusts and other healthcare providers. Staff worked with relevant stakeholders including local commissioners and trust to plan and deliver care.

The service minimised the number of times patients needed to attend the hospital. They could attend the clinic for consultation and diagnostic services on the same day. The service operated one stop clinics including orthopaedic and breast clinics.

Facilities and premises were appropriate for the services being delivered. The service had adequate number of consulting rooms, treatment rooms and waiting areas. Patients had access to beverage making facilities in waiting areas and free car parking was provided on site. The service offered evening and Saturday clinics, which could be more convenient for patients with childcare commitments during the week.

The service had systems to help care for patients in need of additional support or specialist intervention. If a patient was identified as having needs associated with dementia or learning difficulties, then they would work with a relative or carer to ensure the patient was comfortable during visits to the department.

Good

Outpatients

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

All clinical staff had completed training on recognising and responding to patients with mental health needs, disabilities and dementia. They made sure patients identified with complex needs received the necessary care to meet all their needs. Staff told us they identified such patients ahead of their visit and would provide additional time to care for such patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff used communication aids to help patients become partners in their care and treatment.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service displayed information about its interpreting services in the 10 most commonly required languages. The provider informed us they could provide interpretation services for all languages.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. The hospital provided outpatient services to both NHS patients, under contract, and also privately funded patients. Privately funded patients booked appointments at a time and date convenient for them. Staff informed us they aimed to see patients within 48 hours of their booking. Time scales for treatment of NHS patients were set by contracts, which were reviewed every three months, at the time of the inspection the service was meeting their contractual obligations. Most patients were seen within 18 weeks timeframe. Patients waiting longer than 18 weeks were referred, from the NHS, late in their pathway.

Managers worked to keep the number of cancelled appointments to a minimum. There were 13% cancelled appointments between July and December 2022. The provider informed us they did not monitor the reasons for cancellations in outpatient clinics as appointments were rearranged as soon as possible.

Staff provided patients with relevant information and advice following their visits and encouraged them to contact the hospital if they had a questions or concerns.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

Good

Outpatients

The service clearly displayed information about how to raise a concern in patient areas. Patients had access to leaflets which described how to make a comment, compliment or complaint. This included details of how to escalate complaints to an independent body.

The service had a complaint policy which provided guidance to staff on the processes they should follow in the event of a patient complaint. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The service had received 15 complaints between July 2022 and December 2022. All complaints were resolved within the timescale for response.

The service included patients in the investigation of their complaint, we saw examples of letters written to patients explaining the outcome of the service's investigations.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. For example, staff told us a number of complaints were regarding openness about pricing. The service had a dedicated self-pay room and a patient liaison officer for self-pay. Patients had access to leaflets about self-pay and could speak with staff to clarify any issues. Information about charges and costs were displayed in waiting areas.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

We saw good examples of local leadership in the outpatients and physiotherapy departments. The outpatient manager was newly appointed and had been transferred from a sister location. The physiotherapy department was led by a physiotherapy manager who had held the position for a long time. Managers had the skill, knowledge and experience to run the service. They demonstrated an understanding of the challenges to quality and sustainability of the service.

Staff were positive about the leadership of the service. They informed us managers were accessible, visible and approachable. Staff said they felt supported to develop their skills.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Good

Outpatients

There was a clear vision and a set of values. The providers main purpose was to "provide the high quality, safe and compassionate care our patients need and expect". There were four key principles and eight values based on their purpose.

There was a strategy for achieving the priorities and delivering good quality sustainable care. This included a three to five year development plan to review facilities including the outpatient clinic. The strategy also focussed on staff retention and wellbeing.

Staff were familiar with the vision and values and were committed to providing high quality care.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a positive culture within the service. Staff were happy to work for the service and focused on the need of patients. They felt respected, supported and valued. Some of the staff had worked for the organisation for a long time and had been promoted to senior positions.

Staff felt that the provider prioritised staff and patient care. The service had an open culture where patients, their families and staff could raise concerns without fear. Staff recognised the need to be open and transparent with patients when something went wrong in line with the duty of candour requirements. Patients we spoke with were positive about the culture of the service and did not have any concerns to raise.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure with defined roles and responsibilities. Staff at all levels were clear about their roles and accountabilities. The provider had introduced a governance assurance framework in May 2021. This showed how each of the committees or steering groups at locations fed into regional teams and then to the executive board.

The service had a clinical governance committee which included the hospital's executive director, director of clinical services, quality and risk manager, clinical leads and departmental leads including the outpatients' manager and physiotherapy manager. All levels of governance and management functioned effectively.

We reviewed minutes of several meetings, including the clinical governance committee meetings, departmental meetings and medical advisory committee (MAC) meetings. The minutes documented how information on incidents and complaints were investigated and any learning shared. Staff also reviewed risks, staffing, training, audits, policies and clinical practice. The MAC minutes included discussion around quality improvements, clinical outcomes and practising privileges.

The service attended meetings with the local integrated care system where local healthcare priorities were discussed and reviewed.

Managers held regular team meetings and made sure minutes were shared with staff who could not attend. The minutes documented how information on incidents and complaints were investigated and any learning shared and good practice promoted. Staff also reviewed risks, audits, policies, staffing and clinical practice.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Managers monitored local performance and had an overview of all relevant information including risks, incidents and patient outcomes.

The service had arrangements for identifying, recording and managing risks. The hospital had a risk register which included risks in the outpatient and physiotherapy department. The risks were relevant and aligned with our findings during the inspection. Each risk had a risk owner and there were control measures in place to mitigate against them.

The highest risk regarding outpatient and physiotherapy is the risk of incomplete patient records. The risk identified that there was limited access to outpatient consultation/treatment records which posed a risk to continuity of care. In order to mitigate against this risk, a working group was set up to undertake regular auditing of consultant notes. A hospital patient record project was also implemented to merge physiotherapy notes with the full hospital patient record. The service had implemented an action plan to address the issue with a time frame to complete in February 2022.

Minutes of governance meetings showed staff regularly reviewed risks and performance and took action to improve patient care.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff had access to information about patients' care and treatment. Access to individual patient's records was restricted to authorised staff. Electronic devices were password protected and we observed staff signing out of computer systems when they were not in use.

All staff had access to the organisation's intranet to gain information relating to policies, procedures, national guidance and e-learning.

Staff shared information through a variety of ways including at daily meetings, multidisciplinary meetings and governance meetings.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged patients through feedback forms and patient participation group meetings where attendees discussed potential areas of improvement.

Good

Outpatients

Staff told us they felt engaged in the day to day operations of services in outpatients and physiotherapy. They had regular staff meetings which they used to share information relating to incidents or complaints and examples of good practice.

Staff provided feedback via a staff survey. The survey outcome was mostly positive, however, the result was not broken down for staff in outpatients and physiotherapy. Following the survey, the provider reviewed key themes around teamwork, wellbeing, fair pay and giving back to the community. In response to the areas of concerns, the provider invested in staff payment and benefits, charities, leadership programmes, recruitment and staff well-being.

The service collaborated with partner organisations including the local clinical commissioning group, GPs and NHS trust to improve services for patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff were committed to learning and improving services. Staff spoke positively about the opportunities for learning and development which enabled them to assist in improving the services.

The service worked to meet the accessible information standards and make it easy for patients with communication needs to communicate with staff. Staff used communication cards to support patients to maintain their independence when communicating.

Good

Diagnostic imaging

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Requires Improvement

We had not previously rated Safe at this location. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Staff told us they had completed mandatory training and data provided showed mandatory training completion was 100%.

The mandatory training met the needs of patients and staff. Mandatory training included a range of topics such as equality and diversity, fire safety in a hospital environment, patient moving and handling, adult immediate life support and adult basic life support.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and adults formed part of the mandatory training programme for staff. Records showed 100% of staff had received safeguarding children level 2 and safeguarding adults level 3 training.

Staff spoken with had a good understanding of adult safeguarding. The service had up to date safeguarding children and adult policies. Staff knew who to inform if they had concerns and could access support from the safeguarding lead if needed.

Staff spoken with had a good understanding and knowledge of the role and responsibility of a chaperone.

The provider had a up to date chaperone policy which was in date and due for review in June 2024.

Good

Diagnostic imaging

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Cleaning records were up-to-date and demonstrated that areas were cleaned regularly. Clinic areas were clean and had suitable furnishings which were clean and well-maintained. Staff were responsible for cleaning the treatment room. Cleaning schedules in for example the patient changing rooms, mammography room and staff kitchen detailed cleaning to be undertaken when the treatment room was utilised were up to date and signed. Radiographers were responsible for the cleaning of the diagnostic equipment.

The housekeeping team was responsible for all other areas and we saw daily cleaning logs Infection control audits for the period May to December 2022 showed in 5 of the 8 months cleaning was between 97% - 100% compliant. In the 3 months where the service did not achieve 95% action plans were in place to address the issues.

Disposable curtains were in use to screen patients, however in the ultrasound room, the curtain was not dated to indicate when they came into use and when they were due to be renewed.

Imaging rooms had hand washing facilities and hand sanitiser gel dispensers were available throughout the department in line with infection prevention and control guidelines. Staff had access to adequate supplies of personal protective equipment (PPE) such as gloves and aprons. Staff were bare below elbow. Hand hygiene audits were undertaken monthly, recent audits for the period October to November 2022 demonstrated the service scored 100%.

The provider had a up to date Management of Respiratory Infections with Circle Health Group standard operating procedure (SOP).

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had a magnetic resonance imaging (MRI) scanner, X-ray, Ultrasound and a Mammography unit. There was a scanning observation area for the MRI that gave staff visibility of the patient during scanning. There was also a reception and waiting area, changing cubicles and a separate reporting room.

Appropriate signage was displayed outside clinical areas to indicate rooms were in use and should not be entered.

Each modality had separate clinical rooms where the different diagnostic tests would be taken. Each room contained different diagnostic equipment (for example mammogram, ultrasound and X-ray). These rooms were well organised, and appeared clean, and tidy. The clinical rooms allowed private conversations to take place.

The service had two MRI safe trollies and these were clearly labelled. We also saw that a metal drip stand was stored immediately outside the MRI room which was not MRI compatible which could pose a risk.

A resuscitation trolley was located on the unit and was checked daily by staff. Staff completed a checking chart and the seal tag number was recorded and the contents of drawers were checked. A defibrillator was available at the main reception and would be brought to the unit in the case of an emergency.

Electrical appliance safety testing was undertaken annually. A random check of equipment found testing had been undertaken in the last 12 months. Electrical medical equipment (EME) had a registration label affixed.

Sharps bins were available in each clinical room and on the emergency trolly. They were not over filled.

Staff disposed of clinical waste safely. Waste in all clinical areas was separated and in different coloured bags, to identify the different categories of waste and collected separately in clinical waste bins.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. However, there were no protocols for MRI procedures and the mammography radiation risk assessment had not been reviewed within the last 12 months.

The service had a dedicated radiation protection supervisor who took responsibility for radiation safety in the service and a dedicated radiation protection advisor. However, not all the staff we spoke with were aware of who the supervisor and advisor were.

The service had local safety rules in date and due to be reviewed in August 2024. Standard operating procedures for *Ionising Radiation (Medical Exposure) Regulations* (IR(ME)R) were due for review in June 2023. The radiation safety policy was in date and due for review in March 2024 However, we found the mammography radiation risk assessment had passed the view date and was last reviewed in October 2021 and there were no written protocols for MRI procedures. Staff we spoke with advised that these had not been in place for about 18 months.

We observed staff used the Society of Radiographers “Pause and Check” system to ensure the right patients received the right scan at the right time.

All patients were required to complete MRI safety questionnaires which were reviewed by the radiographers and patient prior to any imaging. The safety questionnaires included asking patients if they had cardiac pacemaker, defibrillator or other devices in their chest and female patients were asked if they were pregnant. There was also signage was in place to remind patients to advise staff if they may be pregnant. If the patient brought a chaperone to accompany them whilst they were being scanned, they were asked to complete an MRI visitor and chaperone safety questionnaire prior to the scan.

Gowns were available for patients to change if their clothing contained metal, such as metal zips.

All referrals included patient identification, contact details, clinical history and examination requested, and details of the referring clinician/practitioner.

There was a protocol for resuscitation in place in the event of a medical emergency in the MRI room. The service lead told us there had been a resuscitation simulation in the MRI within the last 3 months however, there was no documentation to support this.

Records showed that 100% of clinical staff had completed adult basis life support and adult immediate life support the training.

Good

Diagnostic imaging

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff an induction.

The service had enough clinical and support staff to keep patients safe. Staff included a one whole time equivalent (WTE) clinical services manager, 2 WTE senior radiographers, 2 WTE radiographers and one WTE apprentice radiographer. The service had 2 WTE diagnostic imaging assistants. Staff told us a WTE deputy manager had been recently appointed and was due to start shortly; their role would be 50% clinical.

During the 12 month period January to December 2022 the service used a total of 5,035 hours of bank and agency staffing (1,274 hours agency usage and 3,761 bank usage). Leaders told us that the current bank and agency usage was 50%, the target within the Circle Health Group was 20%. Staff we spoke with raised concern about the ongoing level of bank and agency usage. A local induction checklist was in place for bank and agency staff

The service did not have any staff vacancies and during the inspection the actual staffing levels were as planned.

Medical staffing

Please see the surgery section for main findings.

The service did not employ any medical staff. Four radiologists held practising privileges at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.

Radiologists who had practising privileges were required to provide an up to date appraisal. At the time of the inspection 100% of the radiologists had an appraisal with in the last 12 months. The provider had an up to date practising privileges policy.

There was also a weekly radiologist on call rota. This ensured that staff were always able to access a radiologist when required.

The radiologists completed reporting on site, but facilities were also available for remote reporting, if required.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Electronic patient records were used to document patient's diagnostic needs and scan results. Patients' personal data and information was kept secure and only staff had access to the information. Staff received training on data security training as part of their mandatory training programme.

Patients MRI safety consent checklist recorded the patients' consent and answers to the safety screening questions were scanned onto the patient record.

Good

Diagnostic imaging

We reviewed five patient MRI records during this inspection and saw records were accurate, mostly complete, legible and up to date. However, in all the records reviewed the safety information was not being completed by the referring clinician. This meant that staff could not be assured there were no contra-indications to MRI. This is an important first step in the safety pathway that was being overlooked and could potentially result in wasted patient visit and appointment if they arrived and contra-indications were found.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff had access to contrast media and medicines which were stored securely, a random stock checked demonstrated these were within date. Fridge temperature were monitored and recorded daily when the service was operational.

Patient group directives (PGD's) were in place for contrast media (Clariscan and Dotarem) for intravenous use with MRI scans and Sodium Chloride. PGDs are written instructions that allow some registered health professionals supply/ administer medicines to pre-defined group of patients.

Staff told us contrast media and medicines were also administered under patient specific directions (PSDs). A PSDs is an instruction to administer a medicine to a list of individually named patients where each patient on the list has been individually assessed by that prescriber.

Allergies were documented when patients received medications. In the event of anaphylaxis (severe allergic reaction) emergency medicines were available.

There were no controlled medicines stored on the unit.

Medical oxygen cylinders were stored securely and were within date.

The service undertook 6 monthly medicines audits, for the period March to August 2022 the department scored 100%.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff raised concerns and reported incidents and near misses in line with the provider's policy. The service used an electronic incident reporting system so all clinical and non-clinical incidents were reported and logged. During the period July to December 2023 staff reported 12 incidents. Of the 12 incidents, 87% (9) were categorised as no harm, 6% (3) were categorised as low harm.

Staff we spoke with knew what incidents to report and how to report them. They told us they were encouraged to report incidents and received good feedback by email. Staff we spoke with told us resolutions from incidents were shared with the rest of the hospital for group learning. Imaging department meeting minutes reviewed recorded that incidents had been discussed.

Is the service effective?

Good

Diagnostic imaging

Inspected but not rated

We do not currently rate effective for diagnostic imaging

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Scans were planned and delivered in line with evidence-based, guidance, standards.

Staff were aware how to access the provider's corporate policies, staff had signed off the local rules to confirm they have been read, understood and will be adhered to.

Nutrition and hydration

Patients had access to drinking water and hot drinks as needed or required whilst in the department.

Pain relief

Staff did not formally assess pain level, but patients were encouraged to take regular painkillers prior to attending the imaging procedures if required.

Staff assisted patients into comfortable positions for imaging wherever possible.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers used information from the audits to improve care and treatment. The service undertook a range of internal audits. These included a 6 monthly radiation protection audit, a quality, governance and compliance audit, and a clinical practice, documentation and observation audit. Picture Archiving and Communication Systems (PACS) and *Radiology* Information System (RIS) audited undertaken annually. Audits were rated using the red, amber and green system (RAG) and the service was rated green (good)action plans were in place to address issues identified where the service had score less than 100%.

Diagnostic reports were usually made available between 1 and 5 days depending on the modality

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

New staff received a local and corporate induction.

Staff spoken with told us there were opportunities for learning and development. Two mammographers were doing an update on mammography course. Staff also undertook role specific training and at the time of the inspection completion was 91%.

Good

Diagnostic imaging

Managers supported staff to develop through yearly appraisals of their work. The appraisal tracker showed staff who were due an appraisal had an appraisal in the last 12 months. Staff had regular supervision; the tracker showed this had been planned for the next 12 months.

Radiologist with practising privileges were required to provide evidence of appraisals, revalidation and professional registrations.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

We saw evidence of good multidisciplinary working between radiologist, radiographers, clinical assistants as well as administrative staff. Staff told us they all worked well as a team and were able to support each other as required.

We also saw that staff on the unit worked well with staff across the hospital to ensure patients admitted at the hospital or attending appointments received their diagnostic procedures.

Seven-day services

Key services were available to support timely patient care.

The service was provided between 8am and 8pm daily, Monday to Friday, and Saturday from 8 am to 1 pm.

Appointments were flexible and could be offered at short notice if required.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service did not undertake health promotion activities.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Prior to a diagnostic procedure patient were required to sign a consent form. Radiographers provided patients with all the information they needed to give informed consent.

Staff we spoke with were aware of the need for consent and gave patients the option of withdrawing their consent and stopping the scan at any time.

Mental capacity act training was covered as part of the safeguarding training for adults. Staff we spoke with were aware of their roles and responsibilities with regards to gaining consent from vulnerable adults. Staff told us they would seek advice from the unit manager and referrer if they had any doubt about a patient's ability to consent.

All staff had access to the consent for assessment, care and treatment policy and mental capacity, deprivation of liberty and restrictive practise policy.

Good

Diagnostic imaging

Is the service caring?

Good

We had not previously rated Caring at this location. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. We observed staff were polite and courteous and took time to interact with patients about treatment and care pathways.

Staff were seen to be considerate and empathetic towards patients. During our inspection, we spoke with three patients, who were all very positive about their care and treatment. One patient told us they felt the care they received was excellent, as their appointments were kept on time, and the staff were helpful. Other patients described the staff as being friendly, professional and caring.

Staff encouraged patients to complete patient satisfaction questionnaires which helped the service review and improve patient experience. Between June and November 2022, 95.7% and 100% of patients rated their overall experience as very good or good.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients emotional support and advice when they needed it. Staff showed sensitivity and support to patients and understood the emotional impact of them undergoing diagnostics. Family members or carers were able accompany patients that required support into the scanning area.

We were provided with feedback from patients. One patient commented 'Appointment time kept, lots of explanations and reassurance as to what was going to happen.' Another said 'Dealt with swiftly and with respect. Procedure outlined in detail; radiographer very reassuring.'

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff spoken with told us patients were given the opportunity to ask questions about the procedure. All the patients we spoke with commented on the timeliness of the appointments.

Feedback from provided from patients included comments such as 'Very friendly staff and told me everything I needed to know', 'Very clear with diagnosis,' ' Staff very kind and caring and explained everything carefully', and 'The technician explained everything thoroughly and put me at ease'.

Good

Diagnostic imaging

We saw no information about fees for diagnostic imaging were displayed in the department and were not available on the providers website.

Is the service responsive?

Good

We had not previously rated Responsive at this location. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service offered diagnostic imaging appointments at the convenience of patients. Patients we spoke with told us they were always offered the earliest appointments and if that wasn't convenient for them other times were offered.

The hospital operated a one stop breast clinic three times per week, the department included mammograms, and ultrasound. The radiographers reported on the day. One patient attending the one stop breast clinic commented 'my appointment has only taken 45 minutes so far'. They were waiting for their report before returning to see their consultant.

Patients were able to book their appointments in person following their consultation at the hospital.

The service provided all the diagnostic imaging for the hospital when requested by surgeons.

The facilities and premises were appropriate for the services that were planned and delivered. There was enough seating in the waiting area where there was a drinks machine and bottled water, changing rooms and toilet facilities including accessible toilets.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, and patients, loved ones and carers could access interpreters or British sign language (BSL) signers when needed. Staff could use a telephone interpreting service for patients whose first language was not English.

Large print documents were also available on request and cold also be provided in different languages. A hearing loop system was available.

The department was on the ground floor and was easily assessible. Disabled toilet facilities were available near the reception area.

Patients had access to hot and cold drinks in the waiting room and could serve themselves whilst waiting for their appointment.

Good

Diagnostic imaging

Records showed dementia awareness training was part of the providers mandatory training programme; 100% of the staff had completed this training.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers did not monitor waiting times. Staff we spoke with told us they could offer appointments normally within seven days, however no evidence was provided to support this. The service advised waiting times were minimal.

Managers worked to keep the number of cancelled appointments to a minimum. Cancelled or missed appointments were recorded electronically and patients were contacted to rebook appointments. In the six month period July to December 2022 a total of 6961 (83.0%) of patients attended their appointment, 1267 (15.11%) cancelled their appointments, 23 (0.27%) patients modified their appointments and 133 (1.59%) did not attend their appointment.

The service had local standard operating procedure (SOP) for patients who did not attend or cancellation of appointment.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Managers shared feedback from complaints with staff and learning was used to improve the service. The service received six complaints in the three month period October to December 2022. The complaints tracker showed complaints were acknowledged and investigated in line with the service's complaints procedure. Imaging department meeting minutes reviewed recorded that complaints had been discussed.

There was no information about how to raise a concern in diagnostic patient waiting area. However, information on how to make a complaint was available on the providers website.

The provider had a complaints policy which was last reviewed in October 2022.

Is the service well-led?

Good

We had not previously rated Well Led at this location. We rated it as good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Good

Diagnostic imaging

There was a clear leadership structure in the service. The imaging clinical service manager had been in post since June 2022 and was responsible for the day to day running of the service. They reported to the director of clinical services. They told us they received support from the wider hospital leadership team

Staff were positive about their immediate manager. They said they were supportive, approachable and felt they worked as a team.

Staff we spoke with told us there were daily huddles and the daily comms meetings minutes sent to all staff.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The diagnostic imagining department had a local vision for the service, this had been incorporated within the hospitals strategic business plan for June 2022. This included expanding the radiology service and increasing the availability of the MRI scanner to offer a six day a week service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

The staff we spoke with were very positive and appeared happy in their role.

Staff felt valued and supported. We observed good teamwork and peer support.

All staff (100%) completed equality and diversity as part of their mandatory training. Staff spoken with felt they could raise concerns with their line manager.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures governance processes, the imaging lead attended the monthly clinical governance meetings.

Staff were clear about their roles and accountabilities. Imaging department meeting minutes demonstrated staff were given feedback from meetings, and incidents and complaints were also discussed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Good

Diagnostic imaging

The diagnostic imaging department had their own risk register which identified two departmental risks, one of which was included on the hospitals risk register. The risks were relevant and aligned with our findings during the inspection. In the diagnostic imaging meeting minutes, we saw staff gave updates on the department risk register.

Staff undertook a variety of daily, weekly and monthly checks to monitor the safety of the service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Electronic patient records were kept secure to prevent unauthorised access and could be accessed easily. Staff were able to locate and access records easily, this enabled them to carry out their day to day roles.

Staff had secure access to the service's intranet, which gave them access to a range of policies, procedures and guidance and their training and personal development records.

The provider had an up to date protection policy. Information governance awareness training was part of the mandatory training programme with 100% staff having completed the training.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service gathered patients' feedback through patient satisfaction questionnaires, which were completed post procedure.

The service provided seven examples of changes made to the service in response to patient feedback from satisfaction surveys and complaints that had been received in the four month period August to November 2022. For example, following a comment from a patient about their appointment running 30 minutes late, the service introduced a sign at our front desk, encouraging patients to check in with the reception team if their appointment was running late.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The service was looking to expand the radiology services offered at the hospital which included offering six day a week service for MRI, upskilling radiographers and equipment.

The service was looking to invest in a new MRI scanner and the provision of a second ultrasound scanning space and developing maxillofacial and dental imaging facilities on the site.

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training and told us they found it useful to support their knowledge.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Clinical staff were trained to level three and the hospital safeguarding lead was trained to level five safeguarding.

All staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. There was a policy to support staff to make safeguarding referrals.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and the safeguarding policy directed them to work with other agencies to protect them.

Good

Surgery

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. They regularly audited their compliance with infection prevention control policies. The environmental infection prevention control audit showed the ward was achieving 100% compliance with policies and the theatres were achieving 97% compliance, above the local acceptance threshold of 95%.

The theatre asepsis audit was consistently rated at 100% compliance and the invasive devices audit was also rated 100% compliance with policies. Hand hygiene audits showed 100% compliance with policy across all areas involved in the surgical pathway.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff we observed in theatres were wearing applicable PPE and were in hospital scrubs. All staff across the surgical team were observed to be bare below the elbow.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff worked effectively to prevent, identify and treat surgical site infections. The infection control lead reviewed any surgical site infections. In the past year there had been three infections, these were found to be different infections and there was no identified clinician link, therefore it was determined these were unfortunate events and not thematically linked.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

All ward rooms were private rooms, with an individual bathroom. In each room patients could reach call bells. The service had suitable facilities to meet the needs of patients' families. There was space in each patient room for relatives to wait while their loved one was in surgery.

The design of the environment followed national guidance. Previously we identified the surgical theatres were not secured. Improvements had been made and now there was a locked door leading to the theatre corridor which required key card access. This meant access was limited to those with a key card or those who were escorted in.

Staff carried out daily safety checks of specialist equipment including checks of resuscitation equipment. The resuscitation checks were confirmed at the daily morning meeting with heads of department.

Theatres completed morning environmental checks, to ensure all necessary equipment was checked, available and signed for each day. There was an end of day checklist also, to ensure theatres had been closed down safely.

The service had enough suitable equipment to help them to safely care for patients. At the daily morning meeting surgical equipment availability was confirmed for the next few days. This was to minimise the chance of last minute cancellations.

The service had safety kits available throughout theatres, including eye wash kits, difficult intubation kits and blood spillage cleaning kits. All staff knew where these were kept for easy access in an emergency.

Throughout the service we observed staff disposed of clinical waste safely using the correct bin. All bins in patient areas clearly listed what could be disposed of in them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and knew how to care for patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and knew how to escalate any concerns appropriately. The tool was modified, where necessary, for different procedures and the last three audits showed 100% compliance. There was a policy describing how to care for deteriorating patients. This policy specified points in care when patients needed to be escalated to specialist teams, including managing patients with suspected sepsis.

All patients had a preassessment phone call with a preassessment nurse, to assess their suitability to have surgery at the hospital. The preassessment nurse used a risk assessment tool to flag any risks, which were reviewed by senior staff to determine a patient's suitability to have surgery at the hospital. Decisions were made within the hospital's inclusion and exclusion criteria. Compliance with preassessment policies was audited twice a year.

Staff completed risk assessments for each patient on admission and knew about and dealt with any specific risk issues. We saw this was routinely recorded in patient records and assessments were repeated, as required.

The service employed a Resident Medical Officer (RMO) to be on site at all times. The RMO was available to care for patients who may become unwell on site and was on site overnight and over weekends to respond to any telephone concerns that might come in.

Staff shared key information to keep patients safe when handing over their care to others. Staff from the ward told us this could be difficult to manage, when surgical lists ran quickly and patients were coming out of theatres regularly. However, they were able to "stop the line" and temporarily pause other patients being taken to theatre to ensure they were able to care properly for the patients recovering post surgery, when they caught up the theatres could start again.

Shift changes and handovers included all necessary key information to keep patients safe. In theatres we observed World Health Organisation (WHO) safer surgery checklists being completed in full. WHO checklists are designed to reduce the likelihood of mistakes being made in theatre.

The service kept an emergency supply of blood for transfusion on site, and stored this in a dedicated blood storage fridge.

At our previous inspection we identified the service did not have an agreement with any local NHS trusts to escalate care of deteriorating patients. Following this, the hospital developed an agreement with their local NHS trust to transfer acutely unwell and deteriorating patients to them. In addition to this, if a patient was not fit for discharge and required overnight care, but was not acutely unwell and needing NHS intervention, the hospital had a transfer agreement with another local Circle Healthcare Group independent hospital that provided overnight care.

Good

Surgery

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, they relied on bank and agency staff in theatres to meet safe levels. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff an induction.

The service had enough nursing and support staff to keep patients safe and data showed that the service consistently met their planned levels of staff.

The theatre lead told us at times theatres relied on agency and bank staffing to ensure they had safe staffing numbers. However, a review of their staffing levels showed, their usage was relatively low at less than 1% for the three months leading up to our inspection.

There was an active recruitment programme to increase the number of nurses available in theatres, with interviews planned for the weeks following inspection.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. We were told if safe staffing levels could not be reached surgical lists were cancelled, where possible this was done ahead of time looking ahead at rotas.

The ward and theatre managers could attempt to adjust staffing levels daily if staff were unwell. Other nearby Circle Health group hospitals worked together to share staff to ensure they were all able to achieve safe staffing levels across the group, without impacting on patient experience or safety.

The service had increasing turnover rates and vacancy rates, but were actively recruiting into the vacant roles. The team was small and therefore small changes in numbers reflected in the turnover and percentage figures.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Surgical lists were booked based on surgeon availability. These lists were then matched with available anaesthetists to ensure safe medical staffing levels were achieved.

Medical staff were all employed using practising privileges, there was a defined process of employment checks for granting practising privileges. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work for an independent hospital.

The service always had an RMO on site at all times. During working hours, the RMO was responsible for supporting staff and caring for any potential deteriorating patients. Outside of clinical hours the RMO remained on site to be a telephone point of contact for patients with any concerns after surgery. The RMO was employed through an agency, who provided the hospital with employment history and records of their competencies and training.

All staff told us consultants were responsive to concerns being raised about their patients outside of their time on site.

Good

Surgery

Records

Staff mostly kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

We reviewed five sets of patient notes and found that most of the information, relating to surgery and risk assessments was comprehensive. However, information was duplicated throughout the notes and was not always recorded. For example, allergy status was on multiple forms throughout the notes. In every set of notes allergy status was completed at least once but was not always recorded on each form. We were told this was a known issue and there was an ongoing project to streamline the notes to remove duplication of information.

When patients transferred between teams, there were no delays in staff accessing their records. Patient notes moved with them between theatres, recovery bays and the ward.

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff completed medicines records accurately and kept them up-to-date. We observed prescribing records being completed in a timely manner, as and when medicines were given to patients.

The service used, stored and checked controlled drugs in line with policy. We were told all agency staff who were needed to administer controlled drugs were asked to complete specific competencies and were added to the controlled drug signing register to ensure complete audit trails were maintained.

The service reviewed antibiotic prescriptions to ensure they were not over-prescribing. They used an external antimicrobial steward to support this review.

As part of the preassessment phone call staff checked any medicines a patient was taking to ensure the team were aware of their medicine history.

Medicines were stored securely and we observed good stock rotation to ensure all medicines were in date, and were being used in a way to minimise wastage.

Staff learned from safety alerts and incidents to improve practice, this was reflected in meeting minutes.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them and told us they raised concerns and reported incidents and near misses in line with hospital policy.

Good

Surgery

The service had two serious incidents in the past 12 months. All staff we spoke with were able to describe learning from the serious incidents.

Managers shared learning with their staff about never events that happened elsewhere in the provider's group.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. We saw that patients were invited to ask questions through the incident review process and they were provided regular updates about the incident report.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at a number of internal meetings.

There was evidence that changes had been made as a result of feedback. Following an incident where biopsies were not labelled thoroughly and had to be retaken staff were aware of the changes to practice and the requirements to label all biopsies thoroughly. Since the changes had been implemented there had not been any similar incidents.

Managers debriefed and supported staff after any serious incident. Following incidents, the hospital held a "swarm". A swarm was a meeting of staff involved in an incident and senior managers at the hospital. This was a chance for an initial debrief from the incident and to identify any immediate mitigations that could be taken to prevent incidents recurring.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies we reviewed were up to date and were version controlled.

There were clear processes and policies for staff to follow to bring new techniques to the hospital. The policy included considering staff training, any national guidance on the technique, whether new equipment or IT work arounds would be needed and consultant ability to carry out the new technique.

The service used nationally recognised tools, such as the WHO surgical safety checklist, to ensure safety of care and standardisation of patient assessments. They audited their usage of the WHO surgical safety checklists and were using them consistently.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Good

Surgery

Staff made sure patients had enough to eat and drink following surgery and completed patients' fluid and nutrition charts where needed. The ward had dedicated support staff who ensured patients were given food as soon as it was safe for them to eat.

Staff used a nationally recognised screening tool to monitor patients' nutrition and audited staff compliance with it. In the six months leading up to inspection the audit demonstrated 100% compliance with documentation.

Patients waiting to have surgery were not left nil by mouth for long periods. The service prioritised patients who may struggle with fasting on surgery lists. For example, diabetic patients were always booked first on lists, and this was clearly flagged in the surgical booking system.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. The service's audit demonstrated 100% compliance with policies for the six months leading to inspection.

Staff told us they knew how to support patients unable to communicate using suitable assessment tools.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive internal programme of repeated audits to check improvement over time. They had an internal audit calendar to ensure patients were being cared for within their policies.

Managers used information from the audits to improve care and treatment. All audits that fell outside of expected ranges had action plans associated with them, to improve the consistency of care for patients. Improvement was checked and monitored by the hospital quality and risk manager.

The hospital noted that they were achieving 100% compliance in many audits and were concerned about the robustness of their processes. To address this, they asked heads of department to provide cross cover for audits. This meant managers were not auditing their own team's performance and therefore removed the potential bias. This had not impacted on their compliance rates.

Managers shared and made sure staff understood information from the audits.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Good

Surgery

Managers gave all new staff a full induction before they started work. The theatre manager explained they were developing a new induction package for staff starting in theatres, to strengthen their support into role.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had received an appraisal in the past year. Staff told us these were useful discussions and helped identify potential areas for development and training opportunities and made sure staff received any specialist training for their role.

Managers worked closely with their teams and told us they supported nursing staff to develop and identified areas for improvement throughout the year.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked closely with each other, regardless of their profession. We observed respectful discussions between staff of all professional backgrounds.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked closely with local NHS trusts to ensure referrals made to them were within their inclusion criteria so patients could safely be treated at the hospital..

Seven-day services

Advice was available seven days a week to support timely patient care.

The service was r open Monday to Friday from 7AM and aimed to discharge all patients by 10PM. They were also open every other Saturday. Outside of these working hours there was always an RMO on site to support patients who were concerned about surgery. Support and guidance was offered over the phone outside of clinical hours, and patients could be bought into clinics in working hours for review.

Health promotion

Health promotion was limited in the service. Patients were advised how to best take care of themselves before and after surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and understood how and when to assess whether a patient had the capacity to make decisions about their care.

When patients could not give consent, staff were clear about processes to make decisions in their best interest, including ensuring relatives had the correct power of attorney paperwork, when applicable.

Good

Surgery

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records. Compliance with consent procedures was regularly audited. The most recent audit showed 98% compliance with policies, and there was an ongoing action plan to achieve 100% compliance.

Clinical staff received and kept up to date with training in the Mental Capacity Act as part of their safeguarding training.

In the past year the service had offered some elective procedures for cosmetic reasons only. For these cases best practice requires a "cooling off" period between discussing a facial cosmetic surgery and the surgery being completed, to give patients a chance to consider their options. In all cases there was a cooling off period between the initial consultation appointment, the preassessment appointment and the surgery date. As the hospital completed preassessments over the telephone patients did not sign their consent form until the day of surgery, when they attended the hospital.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. We observed staff took time to interact with patients and those close to them in a respectful and considerate way. This included when they spoke with patients over the telephone.

Patients said staff treated them well and with kindness. All patients we spoke with told us every member of staff they had met, including clinical and non-clinical, had been kind and took time with them.

Staff followed policy to keep patient care and treatment confidential. Staff carrying out preassessment telephone calls were given private rooms to do so, meaning they were not interrupted or overheard. When patients were on site we observed staff waited until they were in private rooms to speak about confidential matters.

Staff told us they understood and respected the individual needs of each patient and described an understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Patients told us staff gave them and those close to them help, emotional support and advice when they needed it.

If bad news needed to be given to a patient this was done by a consultant, who was supported by the nursing team. This meant there was a team available to answer any questions.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Good

Surgery

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment including providing the cost of treatment.

Staff made sure patients and those close to them understood their care and treatment. All patients we spoke with told us they had multiple conversations with their care team before agreeing for surgery. They told us they were presented with options for care and treatment moving forwards and did not feel pressured to choose a certain pathway.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service had access to communication aids and staff told us they modified their communication method when needed. They gave an example of patients they had cared for with hearing loss who preferred to communicate in writing, rather than use a sign language translator.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service actively sought feedback from patients and offered them multiple ways to provide this feedback. Patients were able to complete feedback cards while they were on site, they were also able to provide feedback online. Patients gave consistently positive feedback about the service.

In the year before inspection the service had an increased number of patients not understanding how paying for private medical care worked. They had created a leaflet to support patients to understand how charging for services worked at the hospital. This was available in addition to the letters patients were sent with quotes for their care before, during and after surgery and the information provided on their website.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. They had quarterly meetings with local NHS trusts to discuss their contracts and to offer support where they were able to accommodate more patients. Managers told us they were cautious about increasing the number of patient pathways they offered to support, as they wanted to ensure they were certain they could meet the needs of those patients so considered extensions carefully.

All patient rooms were individual rooms, with ensuite bathrooms, because of this the service did not have to worry about mixed sex breaches.

Facilities and premises were appropriate for the services being delivered.

When changes were made to the service hospital managers completed an equality impact assessment to ensure the changes would not have unintended consequences for patients with protected characteristics.

Good

Surgery

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Clinical staff received training to support them to care for patients with additional needs. Additionally, patients were encouraged to bring loved ones or carers with them to ensure their anxiety was reduced. Staff also had access to a "dementia box" with activities in to help reduce anxiety for patients living with dementia.

Patients with additional needs were encouraged to complete a communication and information needs passport. This followed them through the service and outlined to staff how each patient preferred to communicate and how to support them to maintain their independence in decision making. Staff had access to communication aids to help patients become partners in their care and treatment.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed, this was arranged at the preassessment appointment. The service preferred to arrange for interpreters to attend on site, for most patients, as they felt this was a smoother process for patients.

Patients were given a choice of food and drink and choices were designed to meet cultural and religious preferences.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with contractual agreements.

The service had a clear access policy. The policy outlined the criteria for patients to be accepted for surgery in the hospital and the checks that needed to be completed. The policy also outlined times in the day general anaesthesia and local anaesthesia could be used. This was because the hospital worked on a day case only model and general anaesthesia took longer for patients to recover from. Therefore, patients requiring a general anaesthesia were booked in the morning or first slot in the afternoon and no later.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. The service provided elective care to both NHS patients, under contract, and also private patients. Time scales for treatment of NHS patients were set by contracts, which were reviewed every three months, at the time of the inspection the service was meeting their contractual obligations. They were consistently seeing the majority of patients within 18 week timeframes. Those who exceeded the 18 weeks were referred to the service, from the NHS, late in their pathway and this waiting was outside the control of the hospital.

Privately funded patients were able to access elective care and treatment quickly, and arranged appointments at times that suited them with surgeon's secretaries.

NHS funded patients followed the same pathway as privately funded patients, including preassessment and follow up.

Good

Surgery

Managers and staff worked to make sure patients did not stay longer than they needed to. Surgical lists were reviewed by heads of departments regularly and were discussed at morning meetings to ensure equipment was readily available on the day to reduce delays.

All patients we spoke with knew the date of their first follow up appointment and their post-surgical care plan.

Managers worked to keep the number of cancelled operations to a minimum. In the six months before the inspection the average cancellation rate was 2.4%. The most common reason for cancellation was patient initiated cancellation, for personal reasons.

Very few patients had their operations cancelled at the last minute. The most common reason for last minute cancellations, accounting for approximately 25% of cancellations, was patient initiated cancellation, for personal reasons. When patients wanted to proceed managers made sure they were rearranged as soon as possible.

Staff worked to make sure that they started discharge planning as early as possible. As the hospital was a day case hospital all patients planned to go home on the day of surgery. Patients were told this from their preassessment telephone call onward and staff checked whether patients had support to get home.

Managers monitored the number of delayed discharges, as the hospital offered a day case service any time a discharge was delayed. If a patient had to be transferred to another service for overnight care the service reviewed the circumstances to prevent it happening again.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. There was clear information in all patient rooms about how to raise a complaint or a concern. Patients we spoke with told us they would be comfortable raising a concern directly with staff, if they felt they needed to.

Staff understood the policy on complaints and knew how to handle them and heads of department investigated complaints and identified themes with hospital managers. The policy included external referrals to arbitration bodies, if required.

Managers shared feedback from complaints with staff and learning was used to improve the service and staff could give examples of how they used patient feedback to improve daily practice. Changes to practice included the increased information about costs provided to patients accessing privately funded care and ensuring they understood what they were being charged for and encouraging patients to check whether they were covered by insurance before agreeing to treatments.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Good

Surgery

Leadership

Leaders were developing the skills and abilities to run the service. They understood and were managing the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The ward leadership had remained stable for a number of years, the manager was knowledgeable about the service, their staff and any concerns.

The theatre leadership had changed three times over the previous 12 months, due to personal circumstances of previous leaders. This meant the theatre lead was new into role, although they had previously worked at the hospital in another role. They told us they were being well supported by the wider hospital leadership team and had agreed a plan for the next year to provide stability and drive theatres forwards.

Heads of department and the wider hospital leadership team were able to access leadership training, we were told leaders who were new into role were encouraged to join training courses to support them as managers.

The service was working towards a succession plan, however, due to the recent changes in leadership this was an ongoing plan of upskilling staff to support them into new roles.

All staff told us the hospital executive director, the director of clinical services, theatre and ward leaders were all visible and approachable and were open to discussions about improvements to the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability and growth of services.

The service had a detailed vision and strategy which was part of the hospital's vision and strategy. This was aligned with the wider provider strategic targets.

The strategy was clear, had detailed development plans for each area within the service and defined metrics for success. The strategy also identified financial input required to achieve goals and a focus on staff retention, wellbeing and engagement with acknowledgement of the importance of this as a driver for change and improvement.

The vision and strategy were shared with staff in a presentation which broke down the strategy into areas that were important to the team.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff told us they felt supported and valued by their local teams and managers. However, some staff felt that the service was influenced by the corporate provider and this put a strain on staff and clinical staff did not all feel valued by the corporate provider.

The service completed an annual staff survey.. The service's overall score from the most recent survey, in 2022, had improved on the previous year. Six of the eight key areas showed improvement, and only two declined. There was an action plan following the survey to drive improvement.

Good

Surgery

The service had a number of ways staff were able to speak out and highlight safety concerns. All staff we spoke with told us they were comfortable speaking out and that when they did speak up they were listened to and actions were taken.

Patients told us they would feel comfortable raising concerns with staff, but they did not have anything they wanted to raise.

The hospital had increased their focus on staff wellbeing in the past year and had two wellbeing champions staff could approach if they were struggling or had ideas for improvements. There were numerous events started to improve team cohesiveness and the service supported local charities to give back to the local community, in response to staff raising this as a concern. This was in addition to a monthly mindfulness newsletter shared with staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear, standardised governance processes to ensure information circulated from the clinical team, to the hospital management and through to the wider corporate provider, and back again.

Within surgery the ward and the theatre teams had team meetings. These meetings had set agendas and staff were encouraged to speak out about risks, areas of excellence, team development and safety concerns. Staff discussed learning from incidents and any policy changes were shared.

These local meetings fed into hospital wide meetings and committees, including risk and governance, infection, prevention and control and medicines management. The hospital wide meetings then fed into the regional committees with other local hospitals from the provider, which finally fed up to the corporate provider. At all levels, information was shared up and down the chain of meetings.

There were also daily meetings, huddles held in each department at 8AM to confirm staffing, share any key messages and responsibilities for the day. There was then a further meeting at 9:45AM with all heads of department across the hospital in attendance to share key messages on staffing, open or new incidents, ongoing complaints and other key messages.

The hospital had a monthly clinical governance committee meeting, which the heads of department attended. There was a clear agenda which included risks, incidents, learning, patient engagement, policy updates and complaints. Minutes were made available for anybody who was unable to attended. Included in the minutes was an action tracker, to clearly log open actions with responsible people identified.

In addition, there was an audit and action log meeting every month, to ensure action plans were being completed to drive improvement. We were told this was a useful meeting with good discussions and support between department managers to identify ways to improve.

The hospital had a medical advisory committee to ensure decisions were made and shared with clinicians. The committee had defined responsibilities and met regularly, with a set agenda for discussions and clear meeting minutes.

Hospital policies defined the roles and responsibilities of different staff groups, ensuring it was clear who was responsible for what actions.

Good

Surgery

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The hospital had a risk register, which included surgical risks, identified by local teams. The risk register was discussed monthly at the clinical governance committee meeting, described above. The risks identified on the risk register all had actions to work to mitigate them, time frames for actions to be completed and staff knew who owned the risk and was responsible for progressing it. The risk register was reflective of our inspection findings.

The highest risk on the risk register, for surgery, was staffing numbers in theatres. The team were working to reduce their vacancies, and their reliance on agency staff, and were confirming plans to improve staffing levels.

The hospital had plans and had taken practical steps to plan for unexpected events. For example, there were generators that were regularly tested, to ensure surgical equipment wouldn't fail in the event of a power cut. The hospital also contracted an external company to run emergency scenario training, to ensure staff were clear about how to manage emergency situations.

There were clear performance management policies, if staff were not meeting expected standards. These were managed by heads of department, if the member of staff was directly employed by the hospital. If the concern was with a clinician under practising privileges the medical advisory committee supported decisions. If concerns were identified with clinician performance the clinical lead shared the concerns with the doctor's NHS employer.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Information such as meeting notes, audit information and outcome data was made available for all staff in a variety of formats. It was saved online, shared via email, shared at meetings and in meeting notes that were pinned to notice boards.

All actions from audits were collated in one document, which was shared with heads of department and was discussed at the 'effective clinical audit meeting'. This meant the service had oversight of all ongoing actions, with review dates and accountable staff identified.

The service, and wider hospital, knew they had a weakness in their records, as discussed in safe. Audits demonstrated that notes did not always contain the level of information required by policy. There was ongoing work to improve this in the short term and also a long term project to digitise patient records and have an electronic patient record. Although some patient records were lacking detail, in all records we reviewed there was the required basic information to provide safe care.

The service had processes to review and action clinical alerts that came in. There were also processes to submit notifications externally, including to CQC.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Good

Surgery

Staff told us they felt able to speak with their managers and the wider leadership team about any concerns or ideas for improvement.

The hospital had a number of ways for patients to engage with them. They ran "patient hour meetings" where a patient was invited to a wider meeting to have input into discussions about patient feedback. They had also started a patient participation group, where a number of patients from the hospital attended to discuss potential areas and ideas for improvement in detail, from a patient's perspective.

The hospital met with the local NHS commissioners four times a year to discuss their contract and how they were performing and to plan for any changes that might be needed.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation.

The service was working to improve their patient records and had a clear short term action plan with a longer term plan to create long lasting improvements.

The service worked to meet the accessible information standards and make it easy for patients with communication needs to communicate with staff. Throughout the service the team had implemented "difficult communication boxes" to give staff the tools to support patients to maintain their independence when communicating.

The service was committed to including patient voice in their improvement projects. They took time to invite comments from patients, in a number of formats and fed these into project plans.

Hospital and service leaders worked to make it as easy as possible for staff to participate in learning, development and improvement in the service. They recognised staff were busy and this sometimes limited their ability to attend meetings so offered drop in sessions to give staff an opportunity to have their voice heard or to ask questions with less rigid time constraints.

Good

Medical care (Including older people's care)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

For mandatory training, safeguarding, nurse staffing, records, assessing and responding to patient risk, medicines and incidents please see surgery.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.

There were processes for ensuring endoscopy equipment was decontaminated safely. These processes followed best practice guidelines.

Theatre staff were responsible for completing the initial bedside clean of equipment. This was then packaged up and sent to an offsite decontamination facility to complete the decontamination process. The infection prevention control lead and endoscopy lead had reviewed the decontamination facilities procedures to ensure their patients were kept safe. There was a service level agreement with the offsite decontamination facility that outlined their responsibilities and that they were required to work within best practice guidelines.

When equipment was returned from the off site decontamination facility it was clearly marked as clean.

Environment and equipment

The service had access to adequate equipment to keep people safe.

Staff told us they had not experienced problems accessing endoscopy equipment in a timely manner. The service level agreement with the decontamination facility had clear timeframes for equipment to be returned to the service once cleaned. This meant the service was able to plan ahead and know what equipment was available, and clean.

Endoscopies were carried out in the same theatres as other surgeries, therefore the endoscopy teams had access to all the supportive and emergency equipment other theatre teams did. See surgical report for further details.

Good

Medical care (Including older people's care)

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Only surgeons who regularly completed endoscopy procedures elsewhere were permitted to carry them out at the hospital. This was agreed within their scope of practice when they joined under practicing privileges. Additionally, clinicians were required to be registered on the national endoscopy database and the national endoscopy training system.

The nursing staff were part of the theatre team, but had completed additional competencies to ensure they were safe to care for patients undergoing endoscopies.

Is the service effective?

Good

We did not previously rate effective. We rated it as good.

For evidence-based care and treatment, pain relief, multidisciplinary working, seven-day services, health promotion and consent, Mental Capacity Act and Deprivation of Liberty Safeguards please see surgery.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and provided specialist advice about fasting or bowel preparation.

We were told staff gave patients advice to support them with their bowel preparation, including fasting advice. This was tailored to the procedure to be carried out and took into account patient specific needs.

When needed staff made sure patients had enough to eat and drink following their endoscopies.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

The service locally audited their performance across a number of key factors every month. In the nine months prior to inspection the service had achieved 100% compliance with their audit.

Outcomes for patients were positive, consistent and met expectations. In the six months prior to inspection there were no reported instances of mortality or readmission following an endoscopy procedure.

Competent staff

The service made sure staff were competent for their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff who supported endoscopy procedures had completed nationally recognised online training and a local competency workbook.

Good

Medical care (Including older people's care)

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Please see surgery

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

For service planning and delivery to meet the needs of the local people, meeting people's individual needs and learning from complaints and concerns please see surgery.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service did not have a waiting list for patients to book their endoscopy. Appointments were booked in line with patient preference and surgeon availability.

As for surgery the service was meeting their contractual obligations with referrals from the NHS and was able to see patients within national timescales, when referrals were made in a timely manner.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

For leadership, vision and strategy, culture, management of risks issues and performance, information management, engagement and learning, continuous improvement and innovation please see surgery.

Governance

Leaders operated effective governance processes. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The service's clinicians were invited to attend the quarterly endoscopy user group meetings for open discussion about any potential changes or developments within the service and their performance.

Good

Medical care (Including older people's care)

The endoscopy user group meeting had a set agenda to cover a range of applicable topics including audit results, learning from incidents, complaints and adherence with key performance indicators. Outcomes from the endoscopy user group meeting were escalated to hospital wide meetings including the clinical governance committee or medical advisory committee.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were no written protocols for MRI procedures. The mammography radiation risk assessment had not been reviewed in the last 12 months.